Section VI
Long Term Care

VA provides Long Term Care (LTC) benefits that are both mandated (for Priority Level 1a) and discretionary (Priority Levels 1b – 7c). Although these services are outside of the Medical Benefits Package (MBP), they were included in the model to assist VA with calculating expected workload and expenditures for these services.

The projected Long Term Care workload and expenditures in the model include three types of Long Term Care services. These services are meant to encompass the LTC services provided by VA. The modeling of these three services, Nursing Home (NH), Skilled Nursing Facility (SNF), and Sustained Treatment and Rehabilitation (STAR), is described in the following subsections. The Non-Acute Psychiatric service line projected for the FY 2002 ELDA has become part of the STAR service line, and is discussed further in the STAR section below. The projected workload is in terms of annual bed days per 1,000 enrollees. Due to limitations in the VHA NH model, admit rates and length of stay projections were not developed.

Nursing Home Services

VHA developed Nursing Home utilization projections for FY 2001 to FY 2012 as part of their Long Term Care planning. This included a projected average daily census (ADC) for each Priority Level of veterans (including Priority Level 1a). The VHA Nursing Home model was used to calculate the projected ADC based on FY 2001 actual veteran enrollment. These census numbers were developed by Priority Level for the following age bands: 21–64, 65–74, 75–84, and 85+. The ADC for each age band and Priority Level was multiplied by 365 to calculate the total NH bed days estimated for FY 2001. These total bed days were then divided by the FY 2001 average veteran enrollees and multiplied by 1,000. This produced expected annual NH days per 1,000 for each Priority Level and age band.

Composite annual NH days per 1,000 were also calculated for the Under Age 65 and Ages 65 and Over Age Groups. These rates were used as the base utilization rates in the model. Relative age factors were developed for all Priority Levels combined based on the expected annual NH days per 1,000 by age band and the composite Under Age 65 and Ages 65 and Over utilization rates. Relative morbidity factors by Priority Level were developed for the Under Age 65 and Ages 65 and Over Age Groups.

Regional NH use variations across the country were estimated during the FY 2002 ELDA. These regional differences are based on regional factors that were recommended for the VA Nursing Home model during a previous VA commissioned review of the model by Milliman (see *Milliman Review of VHA Nursing Home Model* within this section of the report). To validate these differences for Priority Level 1a, the actual VA NH ADC was compared to the total ADC demand produced by the VHA NH Model (without any regional adjustments). The resulting VA market shares varied dramatically across the county and exceeded 100% in VISN 14. When the regional adjustments were applied to the demand produced by the NH Model, the resulting VA market shares had significantly less variation from the national average and results. The resulting VISN 14 market share is more realistic at 68%. Due to VA concerns about the influence of gender in calculating the regional adjustments, these adjustments were dampened by using the square root of the factor in the model and applied only to the projections for Priority Level 1a.

Finally, reliance factors (market share) were developed to adjust the NH demand projections to the level demanded from VA NH resources (VA facilities, VA paid community care, and state homes). For FY 2000, Priority Level 1a veterans were assigned reliance factors by VISN equal to the calculated market share for FY 2000 (utilizing the dampened regional adjustments). The Priority Level 1a reliance factors were then adjusted in constant increments toward 85% in FY 2008. The Priority Level 1a target reliance was set by VA. For Priority Levels 7a and 7c, VA established a set reliance for each year. For Priority Levels 1b through 6, the reliance factors varied over the projection period in order to balance the overall market share levels or ADC targeted by VA. The resulting reliance factors by Priority Level are included in the following table:

Nursing Home Reliance (Market Share Policy) Assumptions

	1a	*1b - 6*	*7a*	*7c*	*Overall*	*ADC*
FY01	38.8%	15.7%	5.0%	5.0%	17.2%	31,941
FY02	45.4%	12.6%	5.0%	5.0%	15.2%	32,181
FY03	52.0%	10.9%	4.0%	4.0%	14.3%	32,985
FY04	58.6%	11.0%	3.0%	3.0%	14.8%	36,675
FY05	65.2%	11.0%	3.0%	3.0%	15.4%	40,689
FY06	71.8%	11.2%	2.0%	2.0%	16.0%	44,670
FY07	78.4%	10.1%	2.0%	2.0%	16.0%	46,947
FY08	85.0%	9.0%	2.0%	2.0%	16.0%	48,800
FY09	85.0%	8.9%	2.0%	2.0%	16.0%	50,222
FY10	85.0%	8.7%	2.0%	2.0%	16.0%	51,367
FY11	85.0%	8.6%	2.0%	2.0%	16.0%	52,026
FY12	85.0%	8.7%	2.0%	2.0%	16.0%	52,470
FY13	85.0%	8.7%	2.0%	2.0%	16.0%	52,707
FY14	85.0%	8.5%	2.0%	2.0%	16.0%	52,411
FY15	85.0%	8.3%	2.0%	2.0%	16.0%	52,144
FY16	85.0%	8.1%	2.0%	2.0%	16.0%	51,817
FY17	85.0%	8.0%	2.0%	2.0%	16.0%	51,482
FY18	85.0%	7.8%	2.0%	2.0%	16.0%	51,210
FY19	85.0%	7.6%	2.0%	2.0%	16.0%	50,674
FY20	85.0%	7.4%	2.0%	2.0%	16.0%	50,102
FY21	85.0%	7.1%	2.0%	2.0%	16.0%	49,443
FY22	85.0%	6.6%	2.0%	2.0%	16.0%	49,298

The basic utilization rates, age, morbidity, regional and reliance adjustments were then integrated into the projection model. The resulting annual utilization rates were paired with the projected NH unit costs (See Section X, VA Unit Costs) to calculate projected expenditures.

Skilled Nursing Facility

Skilled Nursing Facility (SNF) services reflect sub-acute nursing care typically following an acute inpatient episode. In the private sector this care, unlike nursing home care, is covered under private insurance and Medicare. This care requires a medical need and is not just for custodial care. SNF is a service that is included in the LTC services category, though it is not traditionally considered a LTC service in the private sector.

As this service has a private sector counterpart, the utilization rates for bed days of care were developed using the methodology outlined in Section II, Utilization Benchmarks. The utilization rates were developed specifically for each veteran enrollee population. These annual utilization rates

were then paired with the projected SNF unit costs (See Section X, VA Unit Costs) to calculate projected expenditures.

Sustained Treatment and Rehabilitation (STAR)

As a component of their LTC services, VA provides specialized care specifically for psychiatric conditions. The Inpatient Psychiatric service lines in the model project acute care services. VA provides LTC Psychiatric services that are traditionally not covered in the private sector. State facilities provide this care to meet community needs. Therefore, it was necessary to develop a methodology to estimate projected utilization for this type of care.

To model the STAR service line, Milliman and VA staff performed an analysis of VHA Inpatient Psychiatric care. Psychiatric stays were sorted into three categories:

1. Acute stays included in the Inpatient section of the model (modeled as the Inpatient Psychiatric and Substance Abuse service lines)
2. STAR bed section stays
3. Other Non-Acute Psychiatric stays modeled as Non-Medical benefits

The projected utilization in the STAR service line includes LTC psychiatric stays identified from the first two categories of stays using the following methodology.

<u>Category 1</u>

A historical review of VA workload experience data revealed that many bed sections previously used for LTC psychiatric care, such as bed section #71 Long Term Psychiatric, were being utilized less and less by VA. Discussions with VA staff determined that it is likely that many of the stays previously treated under these bed sections were now treated in acute psychiatric bed sections. Therefore, it was necessary to isolate the LTC psychiatric stays from the rest of the stays in the acute psychiatric bed sections. To accomplish this, inpatient acute stays from FY01 VA workload experience files were identified using the bed section mapping and were bundled into complete acute stays using the methodology described in Section IV, VA Workload Data Manipulations.

The resulting psychiatric stays were summarized and reviewed by average length of stay. With VA assistance, it was determined that stays of 75 days or more would reasonably identify the LTC

psychiatric stays. As a result, all psychiatric stays of 75 days or more were removed from the acute psychiatric workload and used as the first component of modeling the STAR service line.

Category 2

The FY 2001 VA workload experience includes a specific STAR bed section (bed section 89). This workload experience was isolated and analyzed using the methodology for developing Non-Medical service projections (see Section VII, Non-Medical Services). The resulting workload projections constitute the second component of the STAR service line.

Composite STAR Service Line

The FY 2001 historical utilization rates of the two LTC psychiatric workload components detailed in Category 1 and 2 were combined to produce the STAR service line projections displayed in the LTC section of the model. These annual utilization rates were then paired with the projected STAR unit costs (see Section X, VA Unit Costs) to calculate projected expenditures.

Development of LTC Millennium Bill, Priority Level 1a Service Lines

The Nursing Home and SNF LTC services developed above were also developed specifically for Priority Level 1a veterans. The bed days per 1,000 and expenditures are included as LTC Millennium Bill service lines within the projection databases. These services were projected separately to assist VA in determining workload and expenditures associated with Priority Level 1a veterans. These veterans are guaranteed access to VA LTC under "The Veterans' Millennium Health Care and Benefits Act," while LTC services provided to all other Priority Levels are discretionary.

Milliman's Review of VHA Nursing Home Model

Sensitivity Testing

VA developed an estimate of about 157,000 NH users, which appears to be a reasonable estimate. This estimate is consistent with NH prevalence rates of about 2.4 times the 1996 Medical Expenditure Panel Survey (MEPS) use rates.

VA developed a methodology to determine the number of current enrollees that will use long term care. Their methodology consists of two main components:

1. Nursing Home Care (NH)
2. Home Health Care (HH)

Milliman's analysis focused on the NH prevalence rates, the corresponding NH users and the distribution of those users and prevalence rates by age and activities of daily living (ADL). VA used 1996 MEPS data to develop NH use rates. These rates were developed by age band and ADL status.

A problem with the methodology was that the distribution of VA enrollee population by age and ADL is not fully known. The NH use rates vary by age and ADL. VA knows the age distribution of the entire enrollee population, but the ADL distribution by age is estimated from a phone survey of only non-institutionalized enrollees. The number of enrollees in a NH is not known nor is their ADL distribution. Therefore, the number of enrollees that currently receive nursing home care were estimated using the following procedure:

a) Estimate the 2001 enrollee population by age band.
b) Apply use rates from MEPS data to the projected enrollee population to develop the expected number of enrollees in a nursing home.
c) Adjust the results in (b) to recognize the increased likelihood that a veteran would need nursing home care. Since there is no credible data available to validate this estimate, the following sensitivity analyses were run:

    1) NH Use Rate = 100% 96 MEPS ÷ NH ADL Dist = 96 MEPS
    2) NH Use Rate = 300% 96 MEPS ÷ NH ADL Dist = 96 MEPS

    Exhibits III-1 and III-2 summarize these results across all Priority Levels. VA believes that overall NH users might be in the range of 150,000 to 160,000 for FY 2001 based on their model. This would equate to roughly 2.4 times the MEPS use rates.
d) Sensitivities 1) and 2) were run assuming that the ADL distribution was identical to that in the MEPS data by age band. It is possible that VA NH users will be skewed toward the higher ADL levels. Therefore, the sensitivities were run again assuming a skewed ADL distribution:

    3) NH Use Rate = 100% 96 MEPS ÷ NH ADL Dist = SKEWED 96 MEPS to higher ADL levels

4) NH Use Rate = 300% 96 MEPS ÷ NH ADL Dist = SKEWED 96 MEPS to higher ADL levels

Exhibits III-3 and III-4 summarize the skewed NH ADL distributions. The shape of the VA ADL distribution was derived from testing performed with the 1985 National Nursing Home Survey (NNHS) and actuarial judgment. The 1985 data is not credible since only 57 out of 1,485 male nursing home users in the survey were in VA nursing homes. However, it is the only source readily available to give any feel for the potential ADL distribution of a VA population in a nursing home. The NNHS does show a significant shift toward the higher ADL levels at the lower ages. The data actually shows a shift in the other direction at the older ages. This may be due to higher proportions of cognitively impaired users or due to a lack of other housing means. The most likely explanation is the lack of credible data. Therefore, only the younger ages were skewed toward the higher levels and the older ages were left alone for the most part. This skewing does not affect the total number of NH users. In addition, the adjustments made were not as drastic as those suggested by the raw NNHS data. Specifically, the MEPS ADL distribution was adjusted as follows:

1996 MEPS ADL Distribution in Nursing Home ADL Score								
Age	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
21–64	0.146	0.074	0.059	0.044	0.160	0.147	0.369	1.000
65–74	0.103	0.035	0.114	0.056	0.152	0.143	0.398	1.000
75–84	0.033	0.083	0.078	0.084	0.116	0.139	0.468	1.000
85+	0.041	0.070	0.087	0.062	0.130	0.125	0.485	1.000

Skewed 1996 MEPS ADL Distribution in Nursing Home ADL Score								
Age	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
21–64	0.096	0.044	0.039	0.044	0.180	0.177	0.419	1.000
65–74	0.053	0.005	0.094	0.056	0.172	0.173	0.448	1.000
75–84	0.033	0.083	0.078	0.084	0.116	0.139	0.468	1.000
85+	0.041	0.070	0.067	0.082	0.130	0.125	0.485	1.000

It is believed that Exhibits VI-1 and VI-3 represent a floor for the number of NH users, about 66,000. Exhibit VI-1 assumes that the distribution of NH users by age and ADL is the same as that in the general population in the 1996 MEPS. The NH prevalence rate for a given age and ADL category is assumed to be the same for VA enrollees and the general population.

It is recognized that the ADL distribution of VA enrollees in the NH is more skewed toward higher ADLs than the general population. Thus, a more skewed distribution was also applied to the range of VA NH users.

Exhibits VI-2 and VI-4 represent an upper bound for VA NH users. A range of two to three times commercial NH frequencies was previously developed in another project involving one of the VISNs, providing a partial basis for Exhibits VI -2 and VI -4.

It was not possible to precisely ascertain the number of VA NH users since the number in the enrollee population is unknown, as is their ADL distribution. VA's estimate of 157,000 NH users falls in the range of values tested and appears reasonable.

The resulting ADL distribution derived from VA's 157,000 NH user estimate contains a number of apparent anomalies. Exhibit VI-5 summarizes the 1996 MEPS ADL distribution, VA's distribution of the 157,000 enrollees and the assumed skewed distribution. It is believed that VA's distribution results from anomalies in the 1996 MEPS prevalence rate survey data. That data likely should be

smoothed. The Milliman prevalence rates could be smoothed more as well, as the 5 ADL and 6+ ADL use rates appear too far apart.

The ADL distribution for those with 3+ ADLs was similar using VA's distribution or the assumed skewed distribution. VA believes that the most likely veterans to be admitted to a NH are those with 3+ ADLs and as a result both ADL distributions result in about the same NH users with 3+ ADLs.

The distribution of NH users by age in Exhibit VI-5 that Milliman developed differs from that developed by VA. The 2.4 multiple of the 1996 MEPS NH use rates were applied uniformly to all ages. It is believed the 2.4 multiple may vary by age, being higher at younger ages and lower at older ages; therefore, VA's number of users at younger ages may be more realistic. However, again, this was difficult to validate given the information currently available.

Future Improvements

Develop A Better Estimate Of NH Users And Their ADL Distribution

It is recommended that VA develop a more precise way to estimate nursing home users. Using a survey similar to the one used to estimate home care users by age and ADL status should be possible. It may need to be a more detailed and intensive survey given the health status of most individuals in these homes, but it should be possible.

If VA does not survey NH residents, then VA should try to validate the results from this model in some way. Perhaps they could do a sampling from some of their larger VISNs in each region of the U.S.

Marital Status

A number of sources have been seen that point out drastically different utilization rates for LTC based on a person's marital status. To the extent that the marital status of the enrolled population is significantly different from the typical marital status of the general U.S. population, VA may want to make adjustments for this within their model.

Incidence and Length of Stay

A significant shift in the private LTC insurance marketplace has been seen recently with respect to frequencies and length of stay. Specifically, frequencies appear to be dropping while length of stay appears to be increasing. Overall, the product of the two appears to be dropping by up to 1% or 2% annually. It is difficult to say whether VA would see a similar pattern; however, it would not be properly reflected in the projections as the model is currently configured. This may be a source of conservatism that could eventually be removed depending on the experience that the enrollee population exhibits.

Area Adjustments

It may be appropriate to adjust utilization rates by area given an initial review by region. The Milliman internal LTC Guidelines include variations in LTC utilization by state. At VA's request, broad area factors by nursing home versus home health care utilization were developed for four regions within the U.S. This was achieved by weighting the state area factors with the enrollee membership by state. The results are shown in the table below. Overall, it appears that VA membership is distributed such that the overall area factor is close to 1.00 for both types of care. However, significant differences do result by region.

VA LTC Utilization Area Factors By Nursing Home and Home Care

Region	Nursing Home	Home Care
Northeast	1.09	0.86
Southeast	0.78	1.42
Northwest	1.49	0.72
Southwest	0.76	0.92
Nationwide	0.99	1.01

Milliman area factors, which vary by state, were mapped to VISNs whenever possible. The definitions of the four areas are summarized in the following table.

Area	VISNs	States
Northwest	13, 14, 15, 19, 20	AK, CO, ID, IA, KS, MN, MO, MT, NE, ND, OR, SD, UT, WA, WY
Southwest	17, 18, 21, 22	AZ, CA, HI, NV, NM, TX
Northeast	1, 2, 3, 4, 5, 10, 11, 12	CT, DE, DC, IL, IN, ME, MD, MA, MI, NH, NJ, NY, OH, PA, RI, VT, WV, WI
Southeast	6, 7, 8, 9, 16	AL, AR, FL, GA, LA, KY, MS, NC, OK, SC, TN, VA

Exhibit VI-1 NH use Rates = 100% of 96 MEPS, NH ADL Distribution = 96 MEPS, Enrollees in NH								
Age	**0 ADL**	**1 ADL**	**2 ADLs**	**3 ADLs**	**4 ADLs**	**5 ADLs**	**6+ ADLs**	**All**
21–64	360	183	145	107	394	362	908	2,458
65–74	1,260	433	1,391	684	1,857	1,746	4,880	12,251
75–84	1,055	2,653	2,490	2,669	3,690	4,420	14,930	31,906
85+	791	1,361	1,680	1,202	2,512	2,415	9,399	19,360
All	3,466	4,630	5,706	4,662	8,452	8,942	30,117	65,976
ADL Distribution Within Age Group								
21–64	0.146	0.074	0.059	0.044	0.160	0.147	0.369	1.000
65–74	0.103	0.035	0.114	0.056	0.152	0.143	0.398	1.000
75–84	0.033	0.083	0.078	0.084	0.116	0.139	0.468	1.000
85+	0.041	0.070	0.087	0.062	0.130	0.125	0.485	1.000
All	0.053	0.070	0.086	0.071	0.128	0.136	0.456	1.000
NH Prevalence Rate By Age & ADL								
21–64	0.0002	0.0007	0.0010	0.0015	0.0068	0.0088	0.0475	0.0009
65–74	0.0016	0.0042	0.0292	0.0285	0.1012	0.0913	0.2767	0.0109
75–84	0.0019	0.0248	0.0508	0.0825	0.2058	0.2088	0.5021	0.0341
85+	0.0231	0.0845	0.2400	0.1612	0.4814	0.3864	0.7894	0.1864
All	0.0011	0.0095	0.0232	0.0338	0.0853	0.1020	0.3842	0.0135

Exhibit VI-2 NH use Rates = 300% of 96 MEPS, NH ADL Distribution = 96 MEPS, Enrollees in NH								
Age	**0 ADL**	**1 ADL**	**2 ADLs**	**3 ADLs**	**4 ADLs**	**5 ADLs**	**6+ ADLs**	**All**
21–64	1,080	549	434	322	1,182	1,085	2,724	7,375
65–74	3,780	1,300	4,174	2,051	5,570	5,238	14,641	36,754
75–84	3,165	7,958	7,469	8,008	11,069	13,259	44,791	95,719
85+	2,373	4,083	5,041	3,606	7,536	7,244	28,197	58,079
All	10,398	13,889	17,118	13,987	25,357	26,826	90,352	197,927
ADL Distribution Within Age Group								
21–64	0.146	0.074	0.059	0.044	0.160	0.147	0.369	1.000
65–74	0.103	0.035	0.114	0.056	0.152	0.143	0.398	1.000
75–84	0.033	0.083	0.078	0.084	0.116	0.139	0.468	1.000
85+	0.041	0.070	0.087	0.062	0.130	0.125	0.485	1.000
All	0.053	0.070	0.086	0.071	0.128	0.136	0.456	1.000
NH Prevalence Rate By Age & ADL								
21–64	0.0006	0.0021	0.0030	0.0044	0.0203	0.0260	0.1303	0.0027
65–74	0.0048	0.0129	0.0844	0.0825	0.2567	0.2356	0.5400	0.0327
75–84	0.0061	0.0759	0.1474	0.2249	0.4555	0.4600	0.7650	0.1023
85+	0.1159	0.3353	0.6352	0.5155	0.8371	0.7771	0.9540	0.5591
All	0.0032	0.0288	0.0683	0.0989	0.2239	0.2627	0.6637	0.0404

Exhibit VI-3 NH use Rates = 100% of 96 MEPS, NH ADL Distribution = SKEWED 96 MEPS, Enrollees in NH								
Age	**0 ADL**	**1 ADL**	**2 ADLs**	**3 ADLs**	**4 ADLs**	**5 ADLs**	**6+ ADLs**	**All**
21–64	237	109	95	107	443	435	1,031	2,458
65–74	647	66	1,146	684	2,102	2,114	5,493	12,251
75–84	1,055	2,653	2,490	2,669	3,690	4,420	14,930	31,906
85+	791	1,361	1,293	1,589	2,512	2,415	9,399	19,360
All	2,731	4,188	5,024	5,049	8,747	9,383	30,853	65,976
ADL Distribution Within Age Group								
21–64	0.096	0.044	0.039	0.044	0.180	0.177	0.419	1.000
65–74	0.053	0.005	0.094	0.056	0.172	0.173	0.448	1.000
75–84	0.033	0.083	0.078	0.084	0.116	0.139	0.468	1.000
85+	0.041	0.070	0.067	0.082	0.130	0.125	0.485	1.000
All	0.041	0.063	0.076	0.077	0.133	0.142	0.468	1.000
NH Prevalence Rate by Age & ADL								
21–64	0.0001	0.0044	0.0007	0.0015	0.0077	0.0106	0.0536	0.0009
65–74	0.0008	0.0006	0.0241	0.0285	0.1130	0.1084	0.3010	0.0109
75–84	0.0019	0.0248	0.0508	0.0825	0.2058	0.2088	0.5021	0.0341
85+	0.0231	0.0835	0.1955	0.2026	0.4814	0.3864	0.7894	0.1864
All	0.0008	0.0086	0.0205	0.0365	0.0880	0.1065	0.3899	0.0135

Exhibit VI-4 NH use Rates = 300% of 96 MEPS, NH ADL Distribution = SKEWED 96 MEPS, Enrollees in NH								
Age	**0 ADL**	**1 ADL**	**2 ADLs**	**3 ADLs**	**4 ADLs**	**5 ADLs**	**6+ ADLs**	**All**
21–64	711	327	286	322	1,330	1,306	3,902	7,375
65–74	1,942	198	3,439	2,051	6,305	6,341	16,479	36,754
75–84	3,165	7,958	7,469	8,008	11,069	13,259	44,791	95,719
85+	2,373	4,083	3,879	4,768	7,536	7,244	28,197	58,079
All	8,192	12,565	15,073	15,148	26,240	28,149	92,559	197,927
ADL Distribution Within Age Group								
21–64	0.096	0.044	0.039	0.044	0.180	0.177	0.419	1.000
65–74	0.053	0.005	0.094	0.056	0.172	0.173	0.448	1.000
75–84	0.033	0.083	0.078	0.084	0.116	0.139	0.468	1.000
85+	0.041	0.070	0.067	0.082	0.130	0.125	0.485	1.000
All	0.041	0.063	0.076	0.077	0.133	0.142	0.468	1.000
NH Prevalence Rate by Age & ADL								
21–64	0.0004	0.0012	0.0020	0.0044	0.0228	0.0311	0.1454	0.0027
65–74	0.0025	0.0020	0.0706	0.0825	0.2811	0.2717	0.5692	0.0327
75–84	0.0061	0.0759	0.1474	0.2249	0.4555	0.4600	0.7650	0.1023
85+	0.1159	0.3353	0.5737	0.5845	0.8371	0.7771	0.9540	0.5591
All	0.0025	0.0261	0.0606	0.1062	0.2299	0.2721	0.6691	0.0404

Exhibit VI-5								
Age	**0 ADL**	**1 ADL**	**2 ADLs**	**3 ADLs**	**4 ADLs**	**5 ADLs**	**6+ADLs**	**All**
Milliman NH User Estimate (Fit to VA's overall NH User Estimate)								
21–64	565	260	228	256	1,058	1,039	2,459	5,865
65–74	1,544	157	2,734	1,631	5,014	5,042	13,104	29,227
75–84	2,517	6,328	5,940	6,368	8,802	10,543	35,618	76,116
85+	1,887	3,246	3,085	3,791	5,993	5,760	22,422	46,185
All	6,514	9,992	11,986	12,046	20,866	22,384	73,603	157,392
VA 2nd Pass NH User Estimate								
21–64	300	253	12,385	1,876	19,753	2,698	7,156	44,422
65–74	1,335	187	3,999	1,800	2,843	16,870	6,468	33,503
75–84	1,272	965	5,468	11,714	2,657	4,427	29,345	55,849
85+	1,361	508	3,564	2,847	919	3,885	10,533	23,617
All	4,268	1,913	25,417	18,238	26,173	27,881	53,503	157,392
Milliman NH User ADL Distribution								
21–64	10%	4%	4%	4%	18%	18%	42%	100%
65–74	5	1	9	6	17	17	45	100
75–84	3	8	8	8	12	14	47	100
85+	4	7	7	8	13	12	49	100
All	4	6	8	8	13	14	47	100
VA NH User ADL Distribution								
21–64	1%	1%	28%	4%	44%	6%	16%	100%
65–74	4	1	12	5	8	50	19	100
75–84	2	2	10	21	5	8	53	100
85+	4	2	15	12	4	16	45	100
All	2	1	16	12	17	18	34	100
Implied Milliman Nursing Home Prevalence Rate Using 96 MEPs by Age, then Skewing Distribution to High ADLs								
21–64	0.0003	0.0010	0.0016	0.0035	0.0182	0.0249	0.1191	0.0021
65–74	0.0018	0.0016	0.0566	0.0663	0.2359	0.2276	0.5106	0.0260
75–84	0.0039	0.0600	0.1184	0.1840	0.3940	0.3983	0.7166	0.0813
85+	0.0535	0.2416	0.4593	0.4703	0.7644	0.6876	0.9291	0.4446
All	0.0018	0.0207	0.0484	0.0853	0.1904	0.2267	0.6126	0.0321
Derived VA Nursing Home Prevalence Rate (same as 96 MEPS)								
21–64	0.0001	0.0010	0.0817	0.0252	0.2751	0.0636	0.3082	0.0162
65–74	0.0015	0.0019	0.0816	0.0740	0.1532	0.6146	0.3746	0.0298
75–84	0.0019	0.0093	0.1075	0.3044	0.1635	0.2230	1.0000	0.0597
85+	0.0274	0.0324	0.4594	0.3457	0.2541	0.4617	1.0000	0.2274
All	0.0011	0.0040	0.0980	0.1254	0.2375	0.2841	0.6657	0.0321